UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

DANIEL VERGU, Plaintiff, v. MICHAEL J. ASTRUE, COMMISSIONER OF SOCIAL SECURITY ADMINISTRATION, Defendant.	NO. ED CV 06-1203 FMO **ORDER Re: JOINT STIPULATION**

PROCEEDINGS

Plaintiff filed a Complaint on November 1, 2006, seeking review of the denial by the Commissioner of the Social Security Administration ("Commissioner") of his application for Disability Insurance Benefits ("DIB") pursuant to Title II of the Social Security Act ("Act"). 42 U.S.C. § 405(g). Thereafter, the parties consented to proceed before the undersigned United States Magistrate Judge. On August 16, 2007, the parties filed a Joint Stipulation ("Joint Stip."). The court has taken the matter under submission without oral argument.

THE FIVE-STEP SEQUENTIAL EVALUATION PROCESS

To be eligible for disability benefits, a claimant must demonstrate a medically determinable impairment which prevents the claimant from engaging in substantial gainful activity and which is expected to result in death or to last for a continuous period of at least 12 months. 42 U.S.C. § 423(d)(1)(A); Tackett v. Apfel, 180 F.3d 1094, 1098 (9th Cir. 1999).

Disability claims are evaluated using a five-step test:

Step one:	Is the claimant engaging in substantial gainful activity? If so, the claimant is found not disabled. If not, proceed to step two.
Step two:	Does the claimant have a "severe" impairment? If so, proceed to step three. If not, then a finding of not disabled is appropriate.
Step three:	Does the claimant's impairment or combination of impairments meet or equal an impairment listed in 20 C.F.R. part 404, subpart P, appendix 1? If so, the claimant is automatically determined to be disabled. If not, proceed to step four.
Step four:	Is the claimant capable of performing his past work? If so, the claimant is not disabled. If not, proceed to step five.
Step five:	Does the claimant have the residual functional capacity to perform any other work? If so, the claimant is not disabled. If not, the claimant is disabled.

20 C.F.R. §§ 404.1520(a)(4) & 416.920(a)(4); Tackett, 180 F.3d at 1098-99. If a claimant is found "disabled" or "not disabled" at any step, there is no need to complete further steps. 20 C.F.R. §§ 404.1520(a)(4) & 416.920(a)(4); Tackett, 180 F.3d at 1098.

BACKGROUND AND SUMMARY OF ADMINISTRATIVE DECISION

Plaintiff, who was 42 years of age on the date of his last administrative hearing, has a high school education. (See Administrative Record ("AR") at 19, 24, 26, 213 & 532).[1] His past relevant work includes employment as a certified nurse's aide and a security guard. (Id. at 24 & 213).

Plaintiff filed for DIB on September 23, 2003, alleging that he has been disabled since February 19, 2001, due to back pain. (See AR at 19, 30 & 85-87). Plaintiff's application was denied initially and upon reconsideration, after which he filed a timely request for a hearing. (Id. at 19, 26-27 & 38).

On July 21, 2005, plaintiff, represented by counsel, appeared and testified at a hearing before an Administrative Law Judge ("ALJ"). (AR at 19, 487, 492-518 & 521-27). Plaintiff's wife,

[1] There is a notation in the AR that plaintiff's initial case folder was lost. (See AR at 112). Thus, the court relies primarily on the Administrative Law Judge's decision and notations in plaintiff's medical records for information regarding his disability application and vocational data.

Magdalena Vergu, also appeared and testified.[2] (Id. at 19 & 519-20). The hearing was continued in order to obtain additional medical records, (see id. at 527-28), and a second hearing was held on October 11, 2005, in which plaintiff, represented by counsel, appeared and testified. (Id. at 19, 530, 541-46 & 555-58). Dr. Samuel Landau, a medical expert ("ME"), Dr. David M. Glassmire, an ME, and Sandra M. Fioretti, a vocational expert ("VE"), also testified. (Id. at 19, 534-41 & 546-61).

The ALJ denied plaintiff's request for benefits on January 23, 2006. (AR at 19-25). Applying the five-step sequential evaluation process, the ALJ found, at step one, that plaintiff has not engaged in substantial gainful activity since his alleged onset date of disability. (Id. at 21). At step two, the ALJ found that plaintiff:

> has the following impairments which are deemed "severe," both individually and in combination: ischemic heart disease, status post angioplasty and stent placement; degenerative disc disease of the lumbar spine, status post fusion and removal of internal fixation hardware; controlled hypertension; history of mild chronic obstructive pulmonary disease secondary to long term smoking improved with inhaler treatment; and chronic alcohol dependence and abuse with anxiety and depressive disorder, not otherwise specified.

(Id.) (bold omitted). At step three, the ALJ determined that the evidence does not demonstrate that plaintiff's impairments, either individually or in combination, meet or medically equal the severity of any listing set forth in the Social Security regulations.[3] (Id. at 23).

The ALJ then assessed plaintiff's residual functional capacity[4] ("RFC"). (See AR at 23). Specifically, the ALJ made the following findings regarding plaintiff's RFC:

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[2] The hearing transcript refers to plaintiff's spouse as "Peggy" Vergu. (AR at 487 & 519).

[3] See 20 C.F.R. pt. 404, subpt. P, app. 1.

[4] Residual functional capacity is what a claimant can still do despite existing exertional and nonexertional limitations. Cooper v. Sullivan, 880 F.2d 1152, 1155 n. 5 (9th Cir. 1989). "Between steps three and four of the five-step evaluation, the ALJ must proceed to an intermediate step in which the ALJ assesses the claimant's residual functional capacity." Massachi v. Astrue, 486 F.3d 1149, 1151 n. 2 (9th Cir. 2007).

> Physically, [plaintiff] is able to lift, carry, push, or pull twenty pounds occasionally, and ten pounds frequently; stand or walk 2 out of 8 hours; and sit 6 out of 8 hours, with customary breaks. [Plaintiff] is occasionally able to stoop, crouch, and climb ramps and stairs. [Plaintiff] is not able to kneel, squat, crawl, and climb ladders, scaffolds, and ropes. [Plaintiff] should avoid all exposure to hazards such as unprotected heights or dangerous moving machinery. [Plaintiff] should not operate motorized equipment, and have no responsibility for the safety of others. [¶] Mentally, absent the effects of his alcohol dependent and abuse, the claimant is able to understand and remember simple instructions, and carry out simple (5-step) tasks. [Plaintiff] is able to have occasional interaction with the general public. [Plaintiff] is unable to perform jobs with a high level of responsibility; and is unable to work at a production-rate pace, [i.e.], assembly-line or conveyor-belt work.

(Id.) (bold omitted). Based on plaintiff's RFC and the VE's testimony, the ALJ found, at step four, that plaintiff "is unable to perform any past relevant work." (Id. at 24) (bold omitted). At step five, based on plaintiff's RFC, vocational factors and the VE's testimony, the ALJ determined that plaintiff is "capable of making a successful adjustment to other work that exists in significant numbers in the national economy[,]" including work as a bench assembler, inspector-packer, and sedentary assembler. (See id. at 25). Accordingly, the ALJ concluded that plaintiff was not suffering from a disability as defined by the Act. (Id. at 20 & 25).

Plaintiff filed a timely request for review of the ALJ's decision, which was denied by the Appeals Council. (AR at 7-10 & 16). The ALJ's decision stands as the final decision of the Commissioner.

STANDARD OF REVIEW

Under 42 U.S.C. § 405(g), a district court may review the Commissioner's decision to deny benefits. The ALJ's findings and decision must be upheld if they are free of legal error and supported by substantial evidence. Mayes v. Massanari, 276 F.3d 453, 458-59 (9th Cir. 2001, as amended Dec. 21, 2001). If the court, however, determines that the ALJ's findings are based on

legal error or are not supported by substantial evidence in the record, the court may reject the findings and set aside the decision to deny benefits. Aukland v. Massanari, 257 F.3d 1033, 1035 (9th Cir. 2001); Tonapetyan v. Halter, 242 F.3d 1144, 1147 (9th Cir. 2001).

"Substantial evidence is more than a mere scintilla, but less than a preponderance." Aukland, 257 F.3d at 1035. Substantial evidence is such "relevant evidence which a reasonable person might accept as adequate to support a conclusion." Reddick v. Chater, 157 F.3d 715, 720 (9th Cir. 1998); Mayes, 276 F.3d at 459. To determine whether substantial evidence supports the ALJ's finding, the reviewing court must review the administrative record as a whole, "weighing both the evidence that supports and the evidence that detracts from the ALJ's conclusion." Mayes, 276 F.3d at 459. The ALJ's decision "'cannot be affirmed simply by isolating a specific quantum of supporting evidence.'" Aukland, 257 F.3d at 1035 (quoting Sousa v. Callahan, 143 F.3d 1240, 1243 (9th Cir. 1998)). If the evidence can reasonably support either affirming or reversing the ALJ's decision, the reviewing court "'may not substitute its judgment for that of the ALJ.'" Id. (quoting Matney ex rel. Matney v. Sullivan, 981 F.2d 1016, 1018 (9th Cir. 1992)).

DISCUSSION

I. THE ALJ IMPROPERLY EVALUATED THE MEDICAL EVIDENCE.

Plaintiff contends that the Commissioner improperly evaluated the medical evidence by failing to provide adequate reasons for rejecting the opinions of plaintiff's treating physician, Dr. G. Sunny Uppal ("Dr. Uppal"), and the examining psychologist, Dr. Margaret A. Donohue ("Dr. Donohue"). (See Joint Stip. at 4-8).

In evaluating medical opinions, Ninth Circuit case law and Social Security regulations "distinguish among the opinions of three types of physicians: (1) those who treat the claimant (treating physicians); (2) those who examine but do not treat the claimant (examining physicians); and (3) those who neither examine nor treat the claimant (nonexamining physicians)." Lester v. Chater, 81 F.3d 821, 830 (9th Cir. 1995, as amended April 9, 1996); see also 20 C.F.R. §§ 404.1527(d) & 416.927(d) (prescribing the respective weight to be given the opinion of treating sources and examining sources). "As a general rule, more weight should be given to the opinion of a treating source than to the opinion of doctors who do not treat the claimant." Lester, 81 F.3d

at 830; accord Benton ex rel. Benton v. Barnhart, 331 F.3d 1030, 1036 (9th Cir. 2003). This is so because a treating physician "is employed to cure and has a greater opportunity to know and observe the patient as an individual." Sprague v. Bowen, 812 F.2d 1226, 1230 (9th Cir. 1987).

Where the treating physician's "opinion is not contradicted by another doctor, it may be rejected only for 'clear and convincing' reasons." Benton, 331 F.3d at 1036; see also Andrews v. Shalala, 53 F.3d 1035, 1041 (9th Cir. 1995) ("While the ALJ may disregard the opinion of a treating physician, whether or not controverted, the ALJ may reject an *uncontroverted* opinion of a treating physician only for clear and convincing reasons.") (italics in original). "Even if the treating doctor's opinion is contradicted by another doctor, the [ALJ] may not reject this opinion without providing specific and legitimate reasons supported by substantial evidence in the record[.]" Lester, 81 F.3d at 830 (internal quotation marks and citation omitted); accord Reddick, 157 F.3d at 725.

"The opinion of an examining physician is, in turn, entitled to greater weight than the opinion of a nonexamining physician." Lester, 81 F.3d at 830; see also 20 C.F.R. §§ 404.1527(d)(1)-(2) & 416.927(d)(1)-(2). If the opinion of an examining physician is rejected in favor of the opinion of a nonexamining physician, the ALJ may do so only by providing specific and legitimate reasons. Lester, 81 F.3d at 830-31. The ALJ can meet the requisite specific and legitimate standard "by setting out a detailed and thorough summary of the facts and conflicting clinical evidence, stating his interpretation thereof, and making findings." Magallanes v. Bowen, 881 F.2d 747, 751 (9th Cir. 1989) (internal quotation marks and citation omitted). Finally, "[t]he opinion of a nonexamining physician cannot by itself constitute substantial evidence that justifies the rejection of the opinion of either an examining physician *or* a treating physician." Lester, 81 F.3d at 831 (italics in original); accord Gallant v. Heckler, 753 F.2d 1450, 1456 (9th Cir. 1984) (ruling that "the report of [a] non-treating, non-examining physician, combined with the ALJ's own observance of claimant's demeanor at the hearing[]" did not constitute "substantial evidence" and, therefore, did not support the Commissioner's decision to reject examining physician's opinion).

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A. Treating Physician.

Dr. Uppal began treating plaintiff on May 6, 2003, for low back, right buttock and leg pain that was initially caused by a work injury plaintiff suffered in 2001, and exacerbated by a more recent bicycle accident. (See AR at 138). Dr. Uppal prescribed pain medication and ordered diagnostic tests. (See id. at 139). On July 29, 2003, Dr. Uppal noted that the results of "EMG/nerve conduction studies . . . show there is peripheral neuropathy."[5] (Id. at 136). On September 11, 2003, Dr. Uppal stated that an MRI of plaintiff's back indicated "a herniated disc . . . [and] weakness of the gastrocnemius-soleus."[6] (Id.). On November 18, 2003, Dr. Uppal indicated that nonoperative treatment had failed to alleviate plaintiff's pain and, after discussing various treatment options with plaintiff, it was determined that plaintiff would undergo back surgery. (See id. at 135). On December 29, 2003, Dr. Uppal performed a multi-procedure surgery on plaintiff's lumbar spine that involved bone grafting and the insertion of screws to fuse the injured area. (See id. at 183-88).

On January 14, 2004, Dr. Uppal became upset with plaintiff when he learned that shortly after the surgery, plaintiff was admitted to the hospital for symptoms related to alcohol withdrawal, whereas before the surgery plaintiff denied any alcohol use. (See AR at 226). On August 31, 2004, Dr. Uppal recommended that, because plaintiff continued to have low back pain, he should undergo another surgery to remove the screws from his spine. (See id. at 221-22). However, Dr. Uppal indicated that the hardware removal surgery should not take place until January 2005, to permit plaintiff sufficient time to recuperate from his heart surgery on August 20, 2004, where a

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[5] "Peripheral neuropathy describes damage to the peripheral nervous system, which transmits information from the brain and spinal cord to every other part of the body. [¶] More than 100 types of peripheral neuropathy have been identified, each with its own characteristic set of symptoms, pattern of development, and prognosis. Impaired function and symptoms depend on the type of nerves – motor, sensory, or autonomic – that are damaged. Some people may experience temporary numbness, tingling, and pricking sensations, sensitivity to touch, or muscle weakness. Others may suffer more extreme symptoms, including burning pain (especially at night), muscle wasting, paralysis, or organ or gland dysfunction." National Institute of Neurological Disorders and Stroke, http://www.ninds.nih.gov.

[6] The gastrocnemius and the soleus are muscles in the calf and foot. See Stedman's Medical Dictionary 708 & 1632 (26th ed. 1995).

stent was placed in one of plaintiff's arteries to alleviate blockage. (See id.; see also id. at 270-71 (operative report of plaintiff's heart surgery on August 20, 2004)). On January 24, 2005, Dr. Uppal removed the screws from plaintiff's lumbar spine. (See id. at 330-31).

On March 30, 2006, Dr. Uppal completed a Multiple Impairment Questionnaire that was submitted to the Appeals Council following denial of plaintiff's disability application by the ALJ. (See AR at 479-86; see also id. at 7-10). Dr. Uppal stated that he has treated plaintiff every four to six weeks for approximately three years and that plaintiff's primary symptoms are chronic low back and leg pain which causes fatigue. (See id. at 479-80). Dr. Uppal also provided that he has been unable to completely relieve plaintiff's pain with medication without unacceptable side effects. (Id. at 481). Regarding plaintiff's functional limitations, Dr. Uppal opined that plaintiff can sit, stand and walk for up to one hour in an eight hour day, but is unable to sit, stand or walk continuously in a work setting. (Id. at 481-82). Plaintiff is able to frequently lift up to 10 pounds, occasionally lift up to 20 pounds, and is significantly limited in his ability to do repetitive reaching, handling, fingering or lifting. (Id. at 482). Plaintiff is also precluded from pushing, pulling, kneeling, bending and stooping. (Id. at 485). In addition, Dr. Uppal indicated that plaintiff is unable to engage in full-time competitive employment and his symptoms would likely increase if he was placed in a competitive work environment. (Id. at 483-84). Dr. Uppal further opined that plaintiff's pain, fatigue and other symptoms would frequently interfere with his ability to concentrate and would cause him to miss more than three days of work per month. (See id. at 484-85). Finally, Dr. Uppal provided that plaintiff is not malingering his symptoms. (Id. at 484).

B. Examining Physician.

On June 1, 2004, Dr. Donohue performed a complete psychological evaluation of plaintiff. (See AR at 212-17). Dr. Donohue diagnosed plaintiff with major depression, moderate in severity, and a history of alcohol abuse in reported remission. (Id. at 216). Dr. Donohue opined that plaintiff is able to follow simple one and two-step instructions that require understanding and memory, but may have difficultly with complex instructions due to psychomotor slowing and depressed mood. (Id.). She further stated that plaintiff may have some difficulty interacting appropriately with other people including the general public because of his irritability due to

depression. (Id.). Finally, Dr. Donohue provided that plaintiff may have some difficulty maintaining adequate attention, concentration, pace and persistence and that with treatment plaintiff's depression should resolve in six to twelve months. (Id.).

C. Analysis.

In determining plaintiff's physical RFC, the ALJ relied on the opinion of Dr. Landau, one of the testifying MEs. (Compare AR at 23 with id. at 536-37). In his discussion of the medical evidence concerning plaintiff's physical limitations, the ALJ stated that plaintiff's "orthopedic status prior to May 2003 was not associated with any clearly serious findings, and the treating orthopedic surgeon findings that led to the spinal fusion surgery in December 2003 were primarily subjective and quite questionable given the surgeon's unawareness of [plaintiff]'s underlying alcohol dependence and abuse and the surgeon's obvious umbrage about [plaintiff]'s lack of candor about the alcohol abuse problem prior to the spinal surgery." (Id. at 23). The ALJ did not consider the Multiple Impairment Questionnaire completed by Dr. Uppal because plaintiff submitted this evidence for the first time to the AC. (See id. at 7-8; see also Joint Stip. at 5). In denying plaintiff's petition for review, the AC rejected Dr. Uppal's opinion, stating that "[t]he questionnaire from Dr[.] Uppal does not contain objective findings that support the limitations described." (AR at 8).

In assessing plaintiff's mental RFC, the ALJ relied on the opinion of Dr. Glassmire, one of the testifying MEs. (Compare AR at 23 with id. at 550-53). The ALJ did not specify whether he adopted or rejected the findings of Dr. Donohue regarding plaintiff's mental limitations. (See, generally, id. at 19-25). In fact, the ALJ's only discussion of Dr. Donohue's assessment was that "the findings of the consultative psychiatric evaluation in June 2004 . . . have shown that [plaintiff]'s cognitive functioning is within normal limits, and his functional impairments are not disabling[.]" (Id. at 23). The RFC adopted by the ALJ, however, is inconsistent with some of Dr. Donohue's findings. For example, the ALJ found that plaintiff could perform simple 5-step tasks and imposed no limitations concerning plaintiff's ability to maintain attention, concentration, persistence and pace. (Compare id. at 23 with id. at 216 (Dr. Donohue's opinion that plaintiff "can follow simple one and two-step instructions" and "may have some difficulty maintaining adequate attention,

concentration, pace, and persistence[]"). Thus, the ALJ implicitly rejected portions of Dr. Donohue's opinion. See Smith ex rel. Enge v. Massanari, 139 F.Supp.2d 1128, 1133 (C.D. Cal. 2001) (reliance on one physician's opinion in making a finding, which differs from that of another physician, is an implicit rejection of the latter).

The Commissioner erred in his evaluation of the medical evidence. First, the court notes that neither Dr. Uppal's nor Dr. Donohue's opinions appear to be contradicted by any other medical evidence in the record. (See, generally, AR at 1-562). Therefore, the ALJ was arguably required to provide clear and convincing reasons for rejecting any portion of the uncontradicted opinions of plaintiff's treating doctor and the examining physician. See Reddick, 157 F.3d at 725 ("Where the treating doctor's opinion is not contradicted by another doctor, it may be rejected only for clear and convincing reasons supported by substantial evidence in the record.") (internal quotation marks and citation omitted); Lester, 81 F.3d at 830 ("[T]he Commissioner must provide 'clear and convincing' reasons for rejecting the uncontradicted opinion of an examining physician.") (internal citation omitted). However, because the ALJ failed to provide even specific and legitimate reasons supported by substantial evidence for his rejection of plaintiff's treating physician's and the examining physician's opinions, it follows that the ALJ's analysis also failed to meet the higher standard of clear and convincing reasons.

Second, to the extent the ALJ rejected Dr. Uppal's and Dr. Donohue's findings, none of the reasons he provided are legally sufficient and/or supported by substantial evidence. There is no evidence in the record to support the ALJ's assertion that Dr. Uppal based his recommendation that plaintiff undergo spinal surgery solely on plaintiff's subjective complaints. (See AR at 23). To the contrary, Dr. Uppal's treatment records reflect that Dr. Uppal's decision to operate was based upon objective medical findings and his clinical observations of plaintiff after treating him for over seven months. (See id. at 131-39). The ALJ also failed to explain how plaintiff's lack of candor in failing to tell Dr. Uppal about his alcohol use before the December 2003 surgery, renders Dr. Uppal's findings invalid. (See id. at 23). In fact, even after learning of plaintiff's alcohol use in early January 2004, (see id. at 133), Dr. Uppal continued to opine that plaintiff was significantly limited by his physical impairments and not malingering his symptoms. (See, e.g., id. at 220-25,

254-58 & 479-86). Moreover, the ALJ failed to provide any reason, let alone a specific and legitimate one, for his implicit rejection of Dr. Donohue's opinion. See Lester 81 F.3d at 830-31.

Finally, the AC's rejection of Dr. Uppal's assessment on the basis that it was not supported by objective findings, (see AR at 8), is belied by the record. At the time he submitted the questionnaire, Dr. Uppal had been treating plaintiff for nearly three years. (See id. at 479; see also id. at 131-39, 220-25 & 254-58). During this period, plaintiff underwent extensive objective testing related to his spinal injury, including EMG/nerve conduction studies, x-rays and MRIs. (See, e.g., id. at 131-39, 220-25 & 254-58). Further, Dr. Uppal indicated in the questionnaire the specific objective laboratory and diagnostic tests that support his opinion concerning the extent of plaintiff's functional limitations. (See id. at 480). Thus, the Commissioner's rejection of Dr. Uppal's opinion is not supported by substantial evidence.

II. REMAND IS APPROPRIATE.

The court has discretion to remand or reverse and award benefits. McAllister v. Sullivan, 888 F.2d 599, 603 (9th Cir. 1989, as amended Oct. 19, 1989). Where no useful purpose would be served by further proceedings, or where the record has been fully developed, it is appropriate to exercise this discretion to direct an immediate award of benefits. See Benecke v. Barnhart, 379 F.3d 587, 595-96 (9th Cir. 2004); Harman v. Apfel, 211 F.3d 1172, 1179-80 (9th Cir. 2000, as amended May 4, 2000), cert. denied, 531 U.S. 1038, 121 S.Ct. 628 (2000). Where there are outstanding issues that must be resolved before a determination can be made, and it is not clear from the record that the ALJ would be required to find plaintiff disabled if all the evidence were properly evaluated, remand is appropriate. See Benecke, 379 F.3d at 595-96; Harman, 211 F.3d at 1179-80.

Here, remand is required because the Commissioner erred in his evaluation of the medical evidence. In light of the court's determination, it is not necessary to reach plaintiff's remaining contention that the ALJ erred in his evaluation of plaintiff's subjective complaints and the lay witness testimony. (See Joint Stip. at 12-14). The court does note, however, that on remand, if the ALJ chooses to reject plaintiff's pain testimony, he must provide clear and convincing reasons

for doing so. See Benton, 331 F.3d at 1040 (absent a finding of malingering, ALJ must provide clear and convincing reasons for disregarding plaintiff's excess pain testimony). Moreover, the ALJ shall reassess plaintiff's wife's testimony and her Third Party Questionnaire, (see AR at 103-11 & 519-20), and if the ALJ chooses to reject any of her statements, he must provide specific reasons germane to the witness for doing so. See Lewis v. Apfel, 236 F.3d 503, 511 (9th Cir. 2001) ("Lay testimony as to a claimant's symptoms is competent evidence that an ALJ must take into account, unless he or she expressly determines to disregard such testimony and gives reasons germane to each witness for doing so.").

In addition, on remand, the ALJ shall reassess the medical opinions in the record and provide sufficient reasons under the applicable legal standard for rejecting any portion of the medical opinions. The ALJ must then consider all of plaintiff's impairments in determining plaintiff's RFC. Next, the ALJ shall, at step five, assess plaintiff's capacity to perform other work existing in significant numbers in the regional and national economies. Finally, the ALJ shall "conduct the five-step inquiry without separating out the impact of alcoholism or drug addiction." Bustamante v. Massanari, 262 F.3d 949, 955 (9th Cir. 2001). "If the ALJ finds that the claimant is disabled and there is medical evidence of . . . [his] drug addiction or alcoholism, then the ALJ should proceed under [20 C.F.R.] §§ 404.1535 or 416.935 to determine if the claimant would still be found disabled if . . . []he stopped using alcohol or drugs." Id. (internal quotation marks, alterations and citation omitted); Lindsay v. Barnhart, 370 F. Supp.2d 1036, 1044 (C.D. Cal. 2005) (observing that it is "it is reversible error for an ALJ to attempt to separate out the impact of a claimant's alcohol abuse before determining whether the claimant is disabled[]").

This decision is not intended for publication.

Based on the foregoing, IT IS ORDERED THAT judgment shall be entered **reversing** the decision of the Commissioner denying benefits and **remanding** the matter for further administrative action consistent with this decision.

Dates this 28th day of September, 2007.

/s/
Fernando M. Olguin
United States Magistrate Judge